STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ((X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155378	A. BUILDING	00	07/18/2013
			B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF	PROVIDER OR SUPPLIE	R		N GRANT ST	
SIGNAT	JRE HEALTHCAR	E AT PARKWOOD	LEBA	NON, IN 46052	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
F000000					
F000000	State Licensul included the ir Complaint INO Complaint INO Federal/State the allegations F364, and F52 Survey Dates: July, 9, 10, 11 2013 Facility Number Provider Number: Survey Team: Lora Brettnack Jeanna King,	0131013. 0131013 substantiated. deficiencies related to a re cited at F362, 20. 12, 15, 16, 17, and 18, er: 000468 ber: 155378 100290270 ner, RN-TC RN RN (July 9, 10, and 11, fype:	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2013 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155378	(X2) MULTIPLE CO A. BUILDING B. WING	00	— СОМ 07/1	e survey pleted 8/2013
	ROVIDER OR SUPPLIER JRE HEALTHCARE AT PARKWOOD	1001 N	ADDRESS, CITY, STATE, ZIP C GRANT ST ON, IN 46052	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.				
	Quality review completed on 07/25/2013 by Brenda Nunan, RN.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 53YG11

Facility ID: 000468

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPL	ETED
		155378	A. BUILDING B. WING			07/18/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	R			GRANT ST		
SIGNATI	IDE HEALTHCAD	E AT PARKWOOD			ON, IN 46052		
	JIL HEALTHOAN	LATTAKWOOD		LLDAIN	ON, IN 40032		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000156 SS=E	483.10(b)(5) - (1 NOTICE OF RIG CHARGES	GHTS, RULES, SERVICES,					
		inform the resident both					
		ing in a language that the					
	•	ands of his or her rights and					
		ulations governing resident					
		ponsibilities during the stay					
	in the facility. Th	ne facility must also provide					
		the notice (if any) of the					
		under §1919(e)(6) of the					
		cation must be made prior to					
		on and during the resident's					
		such information, and any					
		it, must be acknowledged in					
	writing.						
	The facility must	inform each resident who is					
		aid benefits, in writing, at					
		ssion to the nursing facility					
		ident becomes eligible for					
	Medicaid of the i	tems and services that are					
	included in nursi	ng facility services under the					
	•	or which the resident may					
		those other items and					
		facility offers and for which					
		be charged, and the					
		es for those services; and dent when changes are					
		is and services specified in					
		(A) and (B) of this section.					
	1 3 (3/(-)	, , , , , , , , , , , , , , , , , , , ,					
	The facility must	inform each resident					
		time of admission, and					
		ng the resident's stay, of					
		e in the facility and of					
	_	e services, including any					
		ices not covered under					
	iviedicare or by t	he facility's per diem rate.					
	The facility must	furnish a written description					
	of legal rights wh						
	or logar rigino Wi						

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Event ID: 53YG11

Facility ID: 000468

If continuation sheet Page 3 of 70

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378 A. BUILDING B. WING OO COMPLETED 07/18/2013 STREET ADDRESS, CITY, STATE, ZIP CODE	
STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
1001 N GRANT ST	
SIGNATURE HEALTHCARE AT PARKWOOD LEBANON, IN 46052	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC CROSS-REFERENCED TO THE APPROPRIATE	NC
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) DATE	
A description of the manner of protecting	
personal funds, under paragraph (c) of this	
section;	
A description of the requirements and	
procedures for establishing eligibility for	
Medicaid, including the right to request an	
assessment under section 1924(c) which	
determines the extent of a couple's	
non-exempt resources at the time of institutionalization and attributes to the	
community spouse an equitable share of	
resources which cannot be considered	
available for payment toward the cost of the	
institutionalized spouse's medical care in his	
or her process of spending down to	
Medicaid eligibility levels.	
A posting of names, addresses, and	
telephone numbers of all pertinent State	
client advocacy groups such as the State	
survey and certification agency, the State	
licensure office, the State ombudsman	
program, the protection and advocacy network, and the Medicaid fraud control unit;	
and a statement that the resident may file a	
complaint with the State survey and	
certification agency concerning resident	
abuse, neglect, and misappropriation of	
resident property in the facility, and	
non-compliance with the advance directives	
requirements.	
The facility must inform each resident of the	
name, specialty, and way of contacting the	
physician responsible for his or her care.	
The facility must prominently display in the facility written information, and provide to	
residents and applicants for admission oral	
and written information about how to apply	
for and use Medicare and Medicaid benefits,	

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Event ID: 53YG11

Facility ID: 000468

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STATEMEN	ENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION			ONSTRUCTION	X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155378	A. BUII			07/18/2013	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIEF	2					
CIONIATI				l	GRANT ST		
SIGNATO	JRE HEALTHCARE	EATPARKWOOD		LEBAN	ION, IN 46052		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
		ve refunds for previous					
		d by such benefits.					
	Based on inter	view and record	F00	0156	F156-Notice of Rights, Rules,		08/17/2013
	review, the fac	ility failed to provide			Services, Charges: 1. Descr		
	liability notices	to 1 of 3 residents			what the facility did to correct		
	_	otification of Medicare			deficient practice for each clien		
	non-coverage				cited in the deficiency. Reside		
	(Resident #44)				discharged from the facility on 3/28/13 and cannot be specific		
	(1103106111 #44)	•			addressed. 2. Describe how	•	
	 Dooldont #441-	record was reviewed			facility reviewed all clients in the		
		record was reviewed			facility that could be affected by		
		at 10:00 A.M. Resident			the same deficient practice, ar	•	
	#44 was admit	ted to the facility for			state, what actions the facility		
	rehabilitation s	ervices on 3/19/2013			took to correct the deficient		
	and discharged	d to home on			practice for any client the facili	ty	
	_	e record lacked			identified as being affected.		
		to indicated Resident			Facility has audited all current		
		ded a liability notice			residents to ensure all who		
	=	-			should have received notification of Medicare non-coverage liab		
	prior to dischar	ge.			notices, did receive them. No	ility	
					other current residents have b	een	
	•	view on 7/11/13 at			effected by lack of Medicare		
	10:15 A.M., the	e Administrator			non-coverage notification. 3.		
	indicated the fa	acility did not have			Describe the steps or systemic		
	documentation	a "Notice of Medicare			changes the facility has made	or	
	Non-Coverage	" for Resident #44.			will make to ensure that the		
		erview the Administrator			deficient practice does not rec		
	_	dent #44's Medicare			including any in-services, but t		
		ot been exhausted and			also should include any system	n	
					changes you made. Social services, MDS department, ar	ıd	
		ve been provided a			the Business office will be	u	
	liability notice p	orior to her discharge.			in-serviced on Medicare non		
					coverage letter by the		
	3.1-4(a)				administrator on 8/6/13. The		
					administrator or designee will		
					monitor the completion of the		
					Medicare non coverage letters		
					daily (see Attachment A includ		
					with 2567 front page fax). 4.		

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PRINTED: 09/03/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155378	A. BUILDING B. WING	00 	COMPLETED 07/18/2013
	PROVIDER OR SUPPLIEF		1001 N	ADDRESS, CITY, STATE, ZIP CODE GRANT ST ION, IN 46052	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Describe how the corrective action(s) will be monitored to ensure the deficient practice who trecur, i.e., what quality assurance program will be put into place. The results of the audits will be forwarded to the monthly Quality. Assurance Meeting for further recommendation and review. audits will continue daily for 30 days, weekly for 30 days and monthly for 6 months to ensur continued compliance.	The) then

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLE	
		155378	B. WING	G		07/18/2	2013
NAME OF P	PROVIDER OR SUPPLIER	\ \			ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	JRE HEALTHCARE	E AT PARKWOOD			GRANT ST ON, IN 46052		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG F000159 SS=D	483.10(c)(2)-(5) FACILITY MANA FUNDS Upon written auth facility must hold, account for the poresident deposite specified in paragisection. The facility must personal funds in interest bearing a separate from an accounts, and that on resident's funct pooled accounts, accounting for eat The facility must personal funds the non-interest bear interest-bearing at The facility must system that assur separate account accepted account resident's person facility on the resident's on the resident's person	establish and maintain a res a full and complete and ting, according to generally ting principles, of each al funds entrusted to the ident's behalf.		TAG	DEFICIENCY)		DATE
	of resident funds	preclude any commingling with facility funds or with person other than another					
	available through on request to the representative.	ancial record must be quarterly statements and resident or his or her legal					
	The facility must	notify each resident that					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		155378	B. WIN	G		07/18/	2013
	PROVIDER OR SUPPLIEF			1001 N	ADDRESS, CITY, STATE, ZIP CODE GRANT ST ON, IN 46052		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	in the resident's at than the SSI resons specified in section and that, if the arraddition to the varionexempt resource limit for may lose eligibility. Based on obset the facility failed had access to managed by the This deficient presidents intervaccess to persource the facility. Findings included the facility. Findings included the facility. Findings included the facility. Findings included the facility. During an intervacces are available to 3:30 P.M Friday. During an intervacce are available on the weeken at 10:48 A.M., he could not get the facility of the facility of the facility.	3 at 10:30 A.M., an a sign located on the sk indicated, resident ailable from 8:30 A.M. Monday through view on 7/9/2013 at sident #62 indicated, no able to disperse money	F00	0159	F159-Facility Management of Personal Funds: 1. Describe what the facility did to correct to deficient practice for each clien cited in the deficiency. Facility provided access to resident fur available Monday-Friday 8:30a-3:30p and Saturday and Sunday 10a-2p effective July 2013. 2. Describe how the facility reviewed all clients in the facility that could be affected be the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility dentified as being affected. Facility provided access to resident funds available Monday-Friday 8:30a-3:30p and Saturday and Sunday 10a-2p effective July 13, 2013. 3. Describe the steps or systemic changes the facility has made will make to ensure that the deficient practice does not recincluding any in-services, but the all residents and their responsible parties that resident funds are now available 7 days/week	the nt / nds I 13, ne by nd C or ur, this n as er to ible	08/17/2013

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2013 FORM APPROVED OMB NO. 0938-0391

OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING 00	COMPLETED
155378	B. WING STREET ADDRESS, CITY, STATE, ZI	07/18/2013
PROVIDER OR SUPPLIER URE HEALTHCARE AT PARKWOOD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX CROSS-REFERENCED TO T TAG PROVIDERS PLAN OF (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T DEFICIENCY	CORRECTION (X5) NO SHOULD BE COMPLETION
would have to remember to get money out before the weekend because he frequently ordered food from restaurants on the weekends. During an interview on 7/15/2013 at 2:19 P.M., the Administrator indicated, currently the facility did not have a system in place to ensure residents had access to their money managed by the facility during weekends. 3.1-6(f)(1)	effective July 13, 20 facility management in-serviced on the manew process by the on 7/12/13. Busined Department or design complete an audit was ensure that resident obtain funds on the (see Attachment B in 2567 front page fax). Describe how the consure the deficient not recur, i.e., what assurance program into place. The resunaudits will be forward monthly Quality Ass Meeting for further monthly for 6 manual end of the monthly for 6 manual e	13. The It team was ew hours and Administrator less Office gnee will leekly to s are able to weekends included with i. 4. briective intored to practice will quality will be put lts of these ded to the urance eview and ine audits will 30 days and inonths to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DING	00	COMPL	ETED
		155378	A. BUII B. WIN			07/18/	2013
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	t .			GRANT ST		
SIGNATU	JRE HEALTHCARE	E AT PARKWOOD			ON, IN 46052		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDENCE N. AN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
F000225	483.13(c)(1)(ii)-(ii	ii), (c)(2) - (4)					
SS=D	INVESTIGATE/R						
	ALLEGATIONS/I	NDIVIDUALS					
		not employ individuals who					
		guilty of abusing,					
		streating residents by a					
		ave had a finding entered					
		se aide registry concerning					
		nistreatment of residents or					
		of their property; and report has of actions by a court of					
	, ,	nployee, which would					
	_	s for service as a nurse aide					
		aff to the State nurse aide					
	registry or licensi						
	The facility must	ensure that all alleged					
	_	ng mistreatment, neglect, or					
	abuse, including	injuries of unknown source					
	and misappropria	ation of resident property					
	are reported imm						
		he facility and to other					
		lance with State law					
		ed procedures (including to					
	the State survey	and certification agency).					
	The facility	have evidence that all				ļ	
	alleged violations	have evidence that all					
	_	must prevent further					
	J ,	hile the investigation is in					
	progress.	The the investigation is in					
	F. 03. 000.						
	The results of all	investigations must be					
		dministrator or his					
	designated repre	sentative and to other				ļ	
		lance with State law					
	(including to the S						
		cy) within 5 working days of					
		if the alleged violation is					
		te corrective action must					
	be taken.			0005			00/17/2012
	Based on Inter	view and record	F00	0225	F225-Investigate/Report		08/17/2013

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Event ID: 53YG11

Facility ID: 000468

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	LDING	00	COMPL	ETED
		155378	B. WIN			07/18/	/2013
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			GRANT ST		
SIGNAT	URE HEALTHCARE	E AT PARKWOOD			ON, IN 46052		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DESICIENCY).			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL				ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	review, prior to	allowing an employee			Allegations/Individuals: 1.		
	who had been	accused of physically			Describe what the facility did		
	abusing a resid	dent return to work, the			correct the deficient practice f each client cited in the deficie		
	facility failed to	thoroughly investigate			Resident #58 is safe and free	•	
	1	gations for 1 of 3			from any abuse or neglect. 2		
		abuse reviewed. This			Describe how the facility revie		
		ce had the potential to			all clients in the facility that co	uld	
		sident who had contact			be affected by the same defic		
		after she was allowed			practice, and state, what action	ns	
					the facility took to correct the		
	to return to work prior to a thorough				deficient practice for any clien the facility identified as being	ı	
	investigation b	eing completed.			affected. Other residents that	t	
		_			have contact with employee #		
	Findings include	de:			have been interviewed and th		
					safety ensured. 3. Describe	the	
	During an inter	view on 7/10/2013 at			steps or systemic changes the		
	12:55 P.M., Re	esident #58 indicated			facility has made or will make		
	she was talking	g to Staff #44 about			ensure that the deficient pract	ice	
		s when Staff #44 put			does not recur, including any in-services, but this also shou	ld	
	her hands nea	•			include any system changes		
		shook her. Resident			made. The Administrator and		
		don't know what got into			DON were in-serviced by the		
		her office and she			Regional Director of Operation	ns	
	shook me." Re				on proper abuse and neglect		
		by taking both of her			investigation and reporting on		
		· ·			8/2/13. The Social Service Director was in-serviced by th	۵	
	1	cing them on her collar			Administrator on proper abuse		
		ed, "She shook me.			and neglect investigation on		
		sically hurt me but she			8/5/13. All staff will be		
	• •	I don't know what I did			in-serviced on 8/2, 8/5 and 8/0	-	
		at to me. I have			the SSD on abuse and negled	ct	
	1	reporting it to the lady			policy and procedure. The		
	who runs the p	lace but they are			Administrator or designee will review each abuse/neglect		
	friends. Beside	es if she was fired, I			concern for proper investigation	on	
	don't know wha	at would happen to her			using the investigation checkl		
		t want to let it go but if			as a guideline (see Attachmer		
	1	Il you can use my			included with 2567 front page		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		155378	B. WIN		07/18/2013		
			В. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				GRANT ST		
SIGNATI	JRE HEALTHCARE	AT PARKWOOD			ON, IN 46052		
					014, 114 10002		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE	
		t made perfectly clear,			fax). 4. Describe how the		
		r anywhere near me or			corrective action(s) will be monitored to ensure the deficie	ant	
	to speak to me	ever again."			practice will not recur, i.e., wha		
					quality assurance program will		
	During an inter	view on 7/10/2013 at			put into place. The facility will		
	1:11 P.M., the	Administrator and the			include abuse and neglect		
	· ·	sing (DON) were			investigations in our monthly		
		sident #58's allegation			quality assurance review for the		
		both indicated an			next 6 months to ensure defici practice does not recur.	ent	
	1	ould be started.			practice does not recur.		
	IIIVColligation W	ould be started.					
	On 7/15/2012	at 11:30 A.M., the					
		-					
		provided the facility's					
	completed inve	•					
		for the allegation of					
	1	Resident #58. The					
	Administrator v	vas asked if she had					
	provided the co	omplete investigation.					
	She indicated s	she had. The					
	investigation in	dicated the facility had					
	notified the Ind	iana State Department					
		H) of the allegations					
	,	included preventative					
		would be taken. This					
		d a preventative					
	-	-					
		cility would take					
	·	dent interview will be					
	started."						
	_	on indicated Resident					
		lewed by the DON.					
	Resident #58 ii	ndicated to the DON,					
	"It was when	I was upset about					
		rabbed me (pointed to					
		ok me. She didn't hurt					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 53YG11

Facility ID: 000468

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378			ULTIPLE CO LDING	NSTRUCTION 00	COMPL	ETED	
		155378	B. WIN			07/18/	2013
NAME OF F	PROVIDER OR SUPPLIER	1			DDRESS, CITY, STATE, ZIP CODE		
SIGNATU	JRE HEALTHCARE	AT PARKWOOD			ON, IN 46052		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	I was going to have to					
		were around my neck					
		d. I was crying and want to get anyone in					
	•	she should be talked					
		appointed in her. I am					
		appointed in her. I am					
		amed] violence It					
	_	e hallway by her					
		vestigation indicated					
		unsubstantiated and					
		accused of the abuse					
	was allowed to return to work. The						
	complete inves	stigation lacked					
	documentation	any residents other					
	than the reside	nt who made the					
	allegation had	been interviewed. The					
	interviews that	were conducted were					
	from office staf	f. The investigation					
	indicated Staff	#44 indicated she					
		lent #58 in her office.					
	She never talk						
	•	ndicated, "Never					
	touched her sh	,					
	-	shoulders" The					
	_	dicated Staff #44 was					
	•	spended pending the					
	investigation.						
	During an inter	view on 7/16/2013 at					
	_	Administrator stated,					
	· ·	ntiated it. She has a					
		attacks and making					
		ons. I have had to					
		self. Through our					
	,,						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 53YG11

Facility ID: 000468

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL		
AND PLAN	OF CORRECTION	155378		LDING	00	07/18/	
		1	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER			GRANT ST		
SIGNATI	JRE HEALTHCAR	E AT PARKWOOD		LEBAN	ON, IN 46052		
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
Ind		this is what we think		1710			DATE
		When asked if residents					
		ved as was indicated on					
	her report to t	he ISDH. She					
	indicated, she	edid not do the					
	_	and referred me to the					
		ON was asked if she					
		ny residents. She					
		did not." At this time,					
	the Administrator and DON were						
	informed their investigation was not thorough and they needed to interview residents. They indicated						
		art immediately.					
	l tricy would ste	art inimediatory.					
	On 7/17/2013	at 9:00 A.M., the					
		provided interviews					
		s who were recently					
	admitted and	would of had recent					
	contact with S	staff #44. One of those					
	residents had	contact with Staff #44					
		allowed to come back					
	to work prior t	•					
		was completed. A total					
		nt interviews were					
	related to Stat	II denied concerns					
	Telated to Stat	ιι πττ. .					
	A current police	cy titled, "Abuse,					
		/lisappropriation" and					
	_	indicated, "All					
	allegations of	abuse will be					
	investigated and reported to the						
	appropriate a	gencies. The					
	Administrator/	designee will make all					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 53YG11

Facility ID: 000468

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2013 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED			
		155378	B. WING		07/18/2013			
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE				
			1001 N GRANT ST					
SIGNAT	URE HEALTHCARI	E AT PARKWOOD	LEBAN	ON, IN 46052				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE			
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE			
		orts to investigate and						
		ed reports, concerns,						
	and grievance	s"						
	3.1-28(d)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 53YG11

Facility ID: 000468

If continuation sheet Page 15 of 70

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155378				07/18/	2013
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
CICNATI	JRE HEALTHCARE	AT DADKWOOD			GRANT ST ON, IN 46052		
SIGNATO	IKE HEALTHUAKE	AT PARKWOOD		LEDAIN	ON, IN 46052		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000226	483.13(c)						
SS=D		MENT ABUSE/NEGLECT,					
	ETC POLICIES The facility must develop and implement						
		nd procedures that prohibit					
		glect, and abuse of					
		sappropriation of resident					
	property. Based on interview and record						
			F00	0226	F226-Develop/Implement		08/17/2013
	review, the faci	ility failed to implement			Abuse/Neglect, etc Policies: 1		
		vention policies for 1			Describe what the facility did to		
	•	•			correct the deficient practice for		
	of 3 allegations of abuse reviewed. This deficient practice had the potential to affect 1 of 1 resident who				each client cited in the deficier	icy.	
					Resident #58 is safe and free		
	•				from any abuse or neglect. 2. Describe how the facility review	wed	
		th the accused staff			all clients in the facility that cou		
		allowed to return to			be affected by the same defici		
	work and prior	•			practice, and state, what action		
	conducting a th	norough investigation.			the facility took to correct the		
					deficient practice for any client	:	
	Findings includ	e:			the facility identified as being		
					affected. Other residents that		
	During an inter	view on 7/10/2013 at			have contact with employee #4 have been interviewed and the		
	_	sident #58 indicated			safety ensured. 3. Describe to		
	•	to Staff #44 about			steps or systemic changes the		
		when Staff #44 put			facility has made or will make		
	her hands near	•			ensure that the deficient practi	ce	
		shook her. Resident			does not recur, including any		
					in-services, but this also shoul		
		lon't know what got into			include any system changes y	ou	
		her office and she			made. The Administrator and DON were in-serviced by the		
	shook me." Re				Regional Director of Operation	ıs	
		by taking both of her			on proper abuse and neglect	-	
	•	cing them on her collar			investigation and reporting on		
	bone and state	d, "She shook me.			8/2/13. The Social Service		
	She didn't physically hurt me but she				Director was in-serviced by the		
	hurt my pride.	I don't know what I did			Administrator on proper abuse	!	
	* *	at to me. I have			and neglect investigation on		
					8/5/13. All staff will be		

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Event ID: 53YG11

Facility ID: 000468

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155378	A. BUII B. WIN	LDING		07/18/	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
CIONATI	IDE LIEALTUCADE	- AT DADIGNOOD			GRANT ST		
SIGNATO	JRE HEALTHCARE	E AT PARKWOOD		LEBAIN	ON, IN 46052		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	thought about	reporting it to the lady			in-serviced on 8/2, 8/5 and 8/6		
	who runs the p	place but they are			the SSD on abuse and neglec	t	
	friends. Besides if she was fired, I don't know what would happen to her two kids. I just want to let it go but if you have to tell you can use my name. I want it made perfectly clear,				policy and procedure. The		
					Administrator or designee will		
					review each abuse/neglect concern for proper investigation	'n	
					using the investigation checklis		
					as a guideline (see Attachmen		
					included with 2567 front page		
		r anywhere near me or			fax). 4. Describe how the		
	to speak to me	e ever agaın."			corrective action(s) will be		
					monitored to ensure the deficie		
	During an inter	view on 7/10/2013 at			practice will not recur, i.e., wha		
	1:11 P.M., the	Administrator and the			quality assurance program will put into place. The facility will	ре	
	Director of Nur	sing (DON) were			include abuse and neglect		
	informed of Re	esident #58's allegation			investigations in our monthly		
		both indicated an			quality assurance review for th	ne	
		ould be started.			next 6 months to ensure defici		
	investigation w	rodia de startea.			practice does not recur.		
	On 7/15/2013	at 11:30 A.M., the					
		provided the facility's					
	completed inve	•					
		for the allegation of					
		y Resident #58. The					
	Administrator v	was asked if she had					
	provided the co	omplete investigation.					
	She indicated	she had. The					
		ndicated the facility had					
	_	liana State Department					
		H) of the allegations					
	1	,					
	I -	included preventative					
		would be taken. This					
	· •	d a preventative					
		acility would take					
	included, "Res	ident interview will be					
	started."						
	<u> </u>						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 53YG11

Facility ID: 000468

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155378	B. WIN	G		07/18/	∠013
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					GRANT ST		
SIGNATU	JRE HEALTHCARE	AT PARKWOOD		LEBAN	ON, IN 46052		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA*		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	on indicated Resident					
		ewed by the DON.					
		ndicated to the DON,					
	"It was when	I was upset about					
	money. She gi	rabbed me (pointed to					
	shoulders) sho	ok me. She didn't hurt					
	me. I thought I	was going to have to					
	move. Hands	were around my neck					
	pressing in har	d. I was crying and					
	upset. I don't want to get anyone in						
	trouble. I think she should be talked						
to I was disappointed in her. I am							
	still hurt. I was afraid. I was shocked						
	at [Staff #44 named] violence It						
	happened in th	e hallway by her					
	office." The inv	estigation indicated					
		unsubstantiated and					
	the employee a	accused of the abuse					
		return to work. The					
	complete inves	tigation lacked					
	•	any residents other					
		nt who made the					
		been interviewed. The					
	_	were conducted were					
		f. The investigation					
		#44 indicated she					
		ent #58 in her office.					
	She never talke						
		ndicated, "Never					
	touched her sh						
		shoulders" The					
	· •	dicated Staff #44 was					
	_	spended pending the					
	investigation.	ahamaa hamama mo					

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Event ID: 53YG11

Facility ID: 000468

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPI 07/18	LETED	
		100070	B. WIN	_	DDDDGG GWY GTATE TID GODE	07710	72010
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE GRANT ST		
SIGNATU	JRE HEALTHCARE	AT PARKWOOD			ON, IN 46052		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROVIDENCEN AN OF CONDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	During an inter	view on 7/16/2013 at					
	9:35 A.M., the	Administrator stated,					
	"We unsubstar	itiated it. She has a					
	history of panio	attacks and making					
	false accusatio	ns. I have had to					
		self. Through our					
	_	nis is what we think					
		hen asked if residents					
		ed as was indicated on					
	her report to the ISDH. She indicated, she did not do the investigation and referred me to the						
	DON. The DON was asked if she						
	· ·	y residents. She					
		did not." At this time,					
		or and DON were					
		nvestigation was not					
	thorough and the						
		ents. They indicated					
	they would star	t immediately.					
	On 7/17/2013 a	at 9:00 A.M., the					
	Administrator p	provided interviews					
	from residents	who were recently					
	admitted and w	ould of had recent					
	contact with St	aff #44. One of those					
	residents had o	contact with Staff #44					
	after she was a	allowed to come back					
	to work prior to	a thorough					
	investigation w	as completed. A total					
	of four resident	interviews were					
	completed. All	denied concerns					
	related to Staff	#44.					
	A current policy	y titled, "Abuse,					

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Event ID: 53YG11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378		A. BUILDING B. WING A. BUILDING B. WING A. BUILDING B. WING A. BUILDING B. WING B. WING					
	PROVIDER OR SUPPLIER JRE HEALTHCARE AT PARKWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IID PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF THE APP	D BE COMPLETION				
	Neglect and Misappropriation" and dated 4/2013, indicated, "All allegations of abuse will be investigated and reported to the appropriate agencies. The Administrator/designee will make all reasonable efforts to investigate and address alleged reports, concerns, and grievances" 3.1-28(a)						

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Event ID: 53YG11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155378	B. WIN			07/18/2	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	L			GRANT ST		
SIGNATU	JRE HEALTHCARE	AT PARKWOOD		LEBANON, IN 46052			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000247	483.15(e)(2)						
SS=D	RIGHT TO NOTION						
	ROOM/ROOMM/						
		e right to receive notice					
	the facility is char	nt's room or roommate in					
	-	view and record	FOO	0247	F247 Dight to Notice before		08/17/2013
			1 100	0247	F247-Right to Notice before Room/Roommate Change: 1.		06/17/2013
		ility failed to ensure			Describe what the facility did to		
		given notice prior to			correct the deficient practice for		
	_	v roommate. This			each client cited in the deficier		
	deficient praction	ce affected 2 of 3			Roommate placement without		
	residents revie	wed for advance			notification occurred on 4/19/1	3	
	notices being given prior to room				and 6/18/13 and cannot be		
		r room mate changes			specifically corrected. 2.		
	_	and Resident #143).			Describe how the facility review		
	(1.100,001,11.11.21.11				all clients in the facility that co		
	Eindings includ	lo:			be affected by the same defici practice, and state, what actio		
	Findings includ	l C .			the facility took to correct the	113	
	1 Resident #2	27's record was			deficient practice for any client	t	
		15/2013 at 12:54 P.M.			the facility identified as being		
	A quarterly Min				affected. Facility audited all		
		ool (MDS) dated			room changes from 7/18/13 forward to ensure all roommat		
		,			were notified of new roommate		
	,	ed Resident #27 was			placement. 3. Describe the		
		ted without memory			steps or systemic changes the	,	
	problems.				facility has made or will make		
					ensure that the deficient practi	ice	
	During an inter	view on 7/10/2013 at			does not recur, including any		
	10:31 A.M., Re	sident #27 indicated			in-services, but this also shoul		
	she had recent	ly received a new room			include any system changes y	ou	
		not given notice. She			made. The Social Service Department and the Admission	ne	
		ust brought her in as			Department were in-serviced of		
		nember. No notice."			the new room change notificat		
		nomber. NO nonce.			policy and procedure to includ		
	0 0	101			notification to the receiving		
	2. Resident 14				resident by the Administrator of	on	
		15/2013 at 1:00 P.M.			7/19/13. The management tea		
	A quarterly Min	nimum Data			was also in-serviced on the ne	_w I	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155378	A. BUILDING B. WING		07/18/2013
			_	EET ADDRESS, CITY, STATE, ZIP CODE	1
NAME OF F	PROVIDER OR SUPPLIE	R			
CICNATI				1 N GRANT ST	
SIGNATO	JRE HEALTHCAR	EATPARKWOOD	LED	3ANON, IN 46052	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG		DATE
	Assessment T	ool (MDS) dated		form by the Administrator for	back
	6/13/2013. ind	icated Resident #143		up coverage on 7/19/13. Th	
	1	oriented without		Administrator or designee wi	l
	memory proble			monitor the room change	
	I memory proble	21113.		notifications weekly (see	0507
	Danis a sa ista	7/0/0040 -1		Attachment D included with 2 front page fax). Facility	1007
	. •	rview on 7/9/2013 at		implemented new room char	ne
	· ·	esident #143 indicated,		notification forms that include	· .
		n mate change and		notification to receiving room	
	had not been (given notice.		(see Attachment E-1 & E-2	
				included with 2567 front page	e
During an interview on 7/16/2013 at				fax). 4. Describe how the	
2:00 P.M., the Administrator indicated			corrective action(s) will be		
	· ·	nad a room mate		monitored to ensure the defice	
		9/2013 and was unable		practice will not recur, i.e., w	I
	_			quality assurance program w put into place. The results of	
		umentation of a notice		these audits will be forwarde	
	""	her prior to the change.		the Monthly Quality Assurance	
		licated Resident #143		Meeting for further review an	I
	received a nev	v room mate on		recommendation. The audit v	
	6/18/2013, and	d was unable to provide		continue weekly for 30 days	
	documentation	she was given notice		then monthly for 6 months to	
	prior to the cha			ensure continued compliance) .
		90			
	3.1-3(v)(2)				
	0.1-5(V)(Z)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 53YG11

Facility ID: 000468

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155378	B. WING		07/18/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			GRANT ST	
SIGNATI	JRE HEALTHCARE	AT DARKWOOD		ION, IN 46052	
SIGNATO	THE HEALTHOAKE	AT FARRWOOD	LEBAN	ION, IN 48032	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
F000279	483.20(d), 483.20				
SS=D					
	PLANS				
	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes				
			1		
		ctives and timetables to			
	•	medical, nursing, and			
	mental and psychosocial needs that are identified in the comprehensive assessment.				
	•	ist describe the services			
		nished to attain or maintain			
		hest practicable physical,			
		hosocial well-being as 183.25; and any services			
		rise be required under			
		not provided due to the			
	-	e of rights under §483.10,			
		t to refuse treatment under			
	§483.10(b)(4).				
	Based on interv	view and record	F000279	F279-Develop Comprehensive	e 08/17/2013
		ility failed to develop a	1	Care Plans: 1. Describe what	
		mprehensive care plan	1	the facility did to correct the	
		ents reviewed for		deficient practice for each clier	
				cited in the deficiency. Facility	
	nospice care pi	lans (Resident #95).		scheduled a comprehensive ca	are
				meeting with the hospice	
	Findings includ	e:		company on 8/2/13 to write a coordinated hospice care plan	
			1	with measurable goals, specific	
	Resident #95's	chart was reviewed on		interventions to meet goals, ar	
	7/15/2013 at 8:	29 AM. Resident #95		which discipline would be	-
	had diagnoses	which included, but		providing the interventions to	
				meet the goals. 2. Describe h	iow
	were not limited to, mental retardation, hypothyroidism, recurrent			the facility reviewed all clients	
		•		the facility that could be affected	
	•	fections, history of a		by the same deficient practice,	
	nowei obstructi	ion, and epilepsy.		and state, what actions the fac	ility

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Event ID: 53YG11

Facility ID: 000468

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		155378	B. WIN		·	07/18/	2013
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	8			GRANT ST		
SIGNATI	JRE HEALTHCARE	AT PARKWOOD			ON, IN 46052		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG			DATE
					took to correct the deficient	L .	
	Resident #95's	current care plan			practice for any client the facili	ty	
	dated 7/11/13,	indicated, he was			identified as being affected.	ith	
	admitted to Ho	spice care in April			Facility scheduled meetings w all hospice companies current		
		failure to thrive. A goal			providing care to our residents	-	
		I, "Resident will receive			write a coordinated hospice ca		
					plan with measurable goals,	-	
		p [sic] resident's			specific interventions to meet		
		90 days." Approaches			goals, and which discipline wo	uld	
		I, " (1) 4/17/2013 (75)			be providing the interventions		
	Interdisciplinary team of LTC [Long Term Care] staff and Hospice staff to meet/adjust or modify POC [Plan of				meet the goals. 3. Describe t		
					steps or systemic changes the		
					facility has made or will make		
	Care] to meet changing needs of the				ensure that the deficient practi	ce	
	_	ysical, mental and			does not recur, including any in-services, but this also shoul	d	
	•	. (2) 4/17/2013 (76)			include any system changes y		
	· ·				made. All staff has been	ou	
		t's code status. (3)			in-serviced on hospice care to		
	, ,	Care plan meeting			include when they will be at		
	updates with re				facility, what services they will		
	members, hos	pice staff and LTC staff			provide at the facility, and how	to	
	every 90 days	and as needed."			identify that a resident is Hosp		
	Disciplines list	ed to meet these goals			while in the facility by the SDC	on	
	indicated, "hos	_			8/2, 8/5 and 8/6. The MDS		
	I	lisciplinary team] and			Coordinators have been		
		hospice/medical			in-serviced by the DON on	t-a	
	_	•			developing care plans related coordination of Hospice care.	ιο	
	doctor/nursing	J."			The DON or designee will mor	nitor	
					the care plan completion and	iitoi	
	Resident #95's	record lacked			coordination on a monthly bas	is	
	documentation	of a coordinated			for existing residents and with		
	hospice care p	lan which indicated			new hospice admission (see	-	
	measurable go				Attachment F included with 25	67	
		•			front page fax). 4. Describe l	now	
	interventions to meet goals, and/or which discipline would be providing				the corrective action(s) will be		
					monitored to ensure the deficie		
		ns to meet the goals			practice will not recur, i.e., who		
	set for Resider	าt #95.			quality assurance program will		
					put into place. The results of the	16	

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Event ID: 53YG11

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PRINTED: 09/03/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155378	A. BUILDING B. WING	00	COMPLETED 07/18/2013			
	PROVIDER OR SUPPLIER JRE HEALTHCARE AT PARKWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) During on intentions on 7/15/2012 of	TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
	During an interview on 7/15/2013 at 8:40 A.M., Licensed Practical Nurse (LPN) #7 stated, "He is not on Hospice. Last I heard he was going to quit." At this time she looked in Resident #95's chart and stated, "I thought he was off of it." LPN #7 indicated, hospice staff usually came on set days. If they couldn't make it, they would call and the facility staff would intervene and pick up the care. LPN #7 further indicated, the facility care plans and the hospice care plans were kept separate. 3.1-35(a)	m N re co	audits will be forwarded to the nonthly Quality Assurance Meeting for further review and ecommendations. The audits continue monthly for 6 months and with all new admissions to ensure continued compliance.				

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Event ID: 53YG11

Facility ID: 000468

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155378	B. WIN			07/18/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				GRANT ST		
SIGNATU	JRE HEALTHCARE	AT PARKWOOD			ON, IN 46052		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F000282 SS=D	CARE PLAN The services proving facility must be propersons in according written plan of car Based on observing the properson of the plan o	WALIFIED PERSONS/PER wided or arranged by the rovided by qualified dance with each resident's re. ervation, record review, the facility failed to ts were provided care	F00	0282	F282-Services By Qualified Persons/Per Care Plan: 1. Describe what the facility did to		08/17/2013
	based on their This deficient p 42 residents re being provided	written plan of care. bractice affected 2 of viewed for services based on their care t #95 and Resident			correct the deficient practice for each client cited in the deficier Resident #95's helmet was discontinued as a safety device by the physician due to resider refusal to wear his helmet as profinis plan of care. Resident # is now being appropriately transferred with proper	ncy. e nt's part	
	Findings include: 1. Resident #95's chart was reviewed on 7/15/2013 at 8:29 AM. Resident #95 had diagnoses which included, but were not limited to, mental retardation, hypothyroidism, recurrent urinary track infections, history of a bowel obstruction, and epilepsy. Resident #95 was observed sitting in a chair in a common area located by the nurse's station without his helmet on his head on 7/11/2013 at 1:00 P.M. and 1:59 P.M. (staff transferring him from his wheel chair to the recliner at this time, 7/15/2013 at 8:10 A.M., 8:15 A.M., and 8:19 A.M., and during constant observation from 8:30				assistance. 2. Describe how facility reviewed all clients in the facility that could be affected be the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Facility audited all current residents' safety devices to ensure accuracy and appropriateness. All aide assignment sheets were revised with updated safety device information. 3. Describe the steps or systemic changes the facility has made or will make the ensure that the deficient practic does not recur, including any in-services, but this also shoul include any system changes y made. All nursing staff will be in-serviced on the necessity of	ne y nd ty ed to ce d ou	

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Event ID: 53YG11

Facility ID: 000468

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPLETED	
		155378	B. WIN			07/18/2013	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF F	PROVIDER OR SUPPLIE	R			GRANT ST		
SIGNATI	JRE HEALTHCARE	E AT PARKWOOD			ON, IN 46052		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	TE		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	A.M. through 8	3:45 A.M. During this			following all safety devices an		
	time, Resident	:#95 had his helmet in			care plan information provided		
	his hand. Staf	f were busy working			the aide assignment sheets ar nurses to be educated on the	10	
	around the are	ea where Resident #95			need to document any and all		
	was sitting. St	aff were not observed			resident refusals related to sat	fety	
ı	_	ut Resident #95's			devices or plans of care to	·	
ı	helmet on.				determine whether they are		
					effective interventions by the S	SDC	
	An un-timed of	hysician's order dated			on 8/2, 8/5 and 8/6. Unit	the	
		-			managers will be educated on need to keep all aide assignm		
	3/3//13, indicated Resident #95 must have his helmet on when he was up.				sheets current and up to date		
	Have His Hellin	et on when he was up.			ensure resident safety by the		
	A	- d-4- d			DON on 8/6/13. The unit		
	A nurse's note				managers will complete an au		
		30 P.M., indicated,			of all safety devices and care	plan	
		was to have his helmet			information daily to ensure in		
	on when he wa	as out of bed.			place and on the CNA assignment sheets (see		
					Attachment G included with 25	567	
		dated 5/16/2013-9:30			front page fax). 4. Describe	how	
		d, a Certified Nursing			the corrective action(s) will be		
	Assistant (CNA	A) reported she thought			monitored to ensure the defici		
	Resident #95 I	nad a seizure.			practice will not recur, i.e., who		
					quality assurance program will put into place. The results of the		
	A progress dat	ted 6/21/2013-6:00			audits will be forwarded to the		
	A.M., indicated	d, Resident #95 had			Monthly Quality Assurance		
	seizure activity	three times during the			Meeting for further review and		
	night.	•			recommendation. The audit w		
					continue daily for 30 days and		
	A physician's	note dated 6/30/2013,			then weekly for 30 days and the monthly for 6 months to ensur		
		dent #95 ambulated but			continued compliance.		
	had seizures a				,		
ı							
	A current 6/24	/13, care plan					
		ident #95 was at risk					
		jury related to an					
		impulsiveness related					
	l misicady dall,	impulsiveness related				l	

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Event ID: 53YG11

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	OF CORRECTION IDENTIFICATION NUMBER: 155378	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/18/2013
	PROVIDER OR SUPPLIER JRE HEALTHCARE AT PARKWOOD	1001 N	ADDRESS, CITY, STATE, ZIP CODE GRANT ST ON, IN 46052	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	to mental retardation, and a diagnoses of epilepsy. A goal listed indicated, Resident #95 would have risk of injuries related to falls minimized by utilizing safety precaution measures. Approaches listed to meet this goal included ensure Resident #95 had his helmet on when he was up. During an interview on 7/11/2013 at 10:13 A.M., the Director of Nursing (DON) indicated, Resident #95 had a fall on 6/21/2013. During an interview on 7/15/2013 at 8:55 A.M., Licensed Practical Nurse #7 was asked how the CNAs new what special needs each resident required. She indicated they were given assignment sheets. At this time, she provided me with Resident #95's assignment sheet. The assignment sheet lacked documentation he needed to have a helmet on when he was out of bed. She further indicated, Resident #95 always had his helmet on. When informed he did not currently have it on and he had not had it on, she stated, "Well, he takes it off." Resident # 95's care plan lacked documentation of his refusal to wear his helmet.			

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Event ID: 53YG11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155378	B. WIN			07/18/2013	
NAME OF P	PROVIDER OR SUPPLIEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SULTERE			1001 N	GRANT ST		
SIGNATU	JRE HEALTHCARE	E AT PARKWOOD		LEBAN	ON, IN 46052		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	. •	view on 7/15/2013 at					
	9:01 A.M., CN	•					
	1	esident #95) indicated					
		ned when she was					
		o have his helmet on					
	when he was o	out of bea.					
	2 Pacident #1	18's chart was reviewed					
		at 9:06 A.M. She had					
		ich included but were					
		eft below the knee					
		etes, anxiety, cellulitis					
		and depression. A					
	•	num Data Assessment					
		ted 4/2013, indicated					
	·	nad a score of 11 out of					
		S (Brief Interview					
). A score of 11					
		nad moderately					
	impaired cogni	•					
	A current care	plan dated 5/16/2013,					
		dent #18 was a fall risk					
	with a history of	of falls, a recent left					
	below the knee	e amputation,					
		bility and pain. To					
		ransfers, staff were to					
	transfer her wi	th a mechanical lift at					
	all times.						
	During an inter	view on 7/10/2013 at					
	11:10 A.M., Re	esident #18 indicated,					
	she was transf	erred by two staff					
	members "last	Monday". She stated,					
	"I have to slip	o my arm between their					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY SPLETED 8/2013		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	me around and They sat me or and she let go CNA had a hol sliding out of the was sliding out. During an inter 10:10 A.M., with Nursing) and the present, the DO #18 was reliab. During an inter 11:50 A.M., NA called in on he familiar with the and her and ar arms under he	an pick me up and turn it sat me in the chair. In the edge of the chair of me and the other id of me and I started in chair. I yelled out. I stof my chair" It of my chair" It wiew on 7/16/2013 at the DON (Director of the Administrator ON indicated Resident ille 95% of the time. It wiew on 7/16/2013 at it is a standard with the was in day off. She was in day off. She was in the residents on that hall, nother CNA put their in arms and transferred from the bed to her shout a lift.						

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Event ID: 53YG11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED		
		155378	B. WING	3 <u> </u>		07/18/	2013
	PROVIDER OR SUPPLIEF JRE HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG F000312 SS=D	483.25(a)(3) ADL CARE PRO RESIDENTS A resident who is activities of daily necessary service nutrition, groomin hygiene. Based on reconstruction interview, the force residents who with bathing with minimum of 2 states deficient practice residents intervited bathing (Residents included Resident #27's on 7/15/2013 at #27 had diagnous history of a stoweakness and failure. A quark Assessment To 5/7/13, indicated alert and orientersidents in the residents in the resident #27's on 7/15/2013 at #27 had diagnous failure. A quark Assessment To 5/7/13, indicated alert and orienters.	VIDED FOR DEPENDENT s unable to carry out living receives the es to maintain good ng, and personal and oral rd review and facility failed to ensure required assistance ere provided a showers a week. This ce affected 1 of 9 viewed regarding dent #27).	F00	0312	F312-ADL Care Provided for Dependent Residents: 1. Describe what the facility did correct the deficient practice feach client cited in the deficient Resident #27 is now receiving showers as requested. 2. Describe how the facility reviewall clients in the facility that cobe affected by the same deficient practice, and state, what action the facility took to correct the deficient practice for any client the facility identified as being affected. Facility interviewed residents or their responsible parties to ensure all residents shower needs were being me Facility will revise aide assignment sheets to include additional shower requests. Describe the steps or systemic changes the facility has made will make to ensure that the deficient practice does not recincluding any in-services, but	to for ncy. ewed ould ient ons t all t. 3. c or cur, this	DATE 08/17/2013
	10:25 A.M., Reshe thought sh	rview on 7/10/2013 at esident #27 indicated ee only received one and she could use two ets "sweaty".			also should include any syste changes you made. The nurs staff will be in-serviced on the policy and procedure for completing showers to include what to do when a resident refuses and following the CNA assignment sheets for special	sing e A	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378			LDING	onstruction 00	(X3) DATE S COMPLI 07/18/2	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	1:16 P.M., Regindicated show in the hard charand some were the kiosk. He is showers a weet standard and it would be noted and the care pland the shower shower shower shower shower shower shower on the second we 3/14). She received one showers given available. She the first week of shower on May second week of the second w	view on 7/15/2013 at pistered Nurse #1 rers were documented art on shower sheets being documented in further indicated, two ex was the minimum for a resident refused it don the documentation an. at 9:26 A.M., the provided documentation an. at 9:26 A.M., the provided documentation an. at 9:26 A.M., the provided documentation and the following for the ch, May, June, and and the following for the provided documentation and the following for the provided and the following for the following for the following for the first following following following following following following following following follow			requests by the SDC on 8/2, 8 and 8/6/2013. The unit managers will monitor the ADI books and interview 2 resident daily to ensure showers are completed as requested and a minimum of two times a week (see Attachment H included w 2567 front page fax). 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice w not recur, i.e., what quality assurance program will be put into place. The results of the audits will be forwarded to the monthly Quality Assurance Meeting for further review and recommendation. The audits w continue daily for 30 days and then weekly for 30 days and then weekly for 6 months to ensure continued compliance.	t a tth vill	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155378	A. BUILDING	00	COMPLETED 07/18/2013			
		100010	B. WING		07/18/2013			
NAME OF P	ROVIDER OR SUPPLIE	2		ADDRESS, CITY, STATE, ZIP CODE				
SIGNATI	JRE HEALTHCARE	- AT PARKWOOD	1001 N GRANT ST LEBANON, IN 46052					
				T	(15)			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION			
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE			
	on June 14. du	iring the second week						
		14). She received one						
	shower on Jun	e 28, during the 4th						
	week of June (6/22- 6/30). She						
		hower on July 12, 2013						
	for the second	•						
		cumentation was						
		ndicated Resident #27						
	refused showe	rs.						
	Pevious of a co	rrent policy titled,						
		dated 12/10, provided						
		trator on 7/17/2013 at						
	•	cated, "The residents						
	will be provide							
	•	least two (2) times per						
	week accordin	g to established shower						
	schedule"							
	3.1-38(3)(b)(2)							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155378	B. WIN			07/18/	2013
NAME OF D	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	KO VIDEK OK SOI I EIEN				GRANT ST		
SIGNATU	JRE HEALTHCARE	E AT PARKWOOD		LEBAN	ION, IN 46052		
(X4) ID		TATEMENT OF DEFICIENCIES	PREFIX (EACH CORRECTIVE AC CROSS-REFERENCED T		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F000323 SS=D	483.25(h) FREE OF ACCID	FNT					
00-D		ERVISION/DEVICES					
		ensure that the resident					
		ains as free of accident					
	•	ssible; and each resident					
	receives adequate supervision and assistance devices to prevent accidents.						
		view, and record	FUU	0323	F323-Free of Accident		08/17/2013
		ility failed to utilize a	1.00	0323	Hazards/Supervision/Devices:	1.	00/1//2013
		mechanical lift to			Describe what the facility did to	0	
		lent resulting in pain			correct the deficient practice for		
		nping the resident's leg			each client cited in the deficier	icy.	
	•	sfer. This deficient			Resident #18 is now being appropriately transferred with		
	•	ed 1 of 4 residents			proper assistance. 2. Describ	e.	
	•				how the facility reviewed all		
		ccidents (Resident			clients in the facility that could		
	#18).				affected by the same deficient		
	Findings includ	la.			practice, and state, what action	ns	
	Findings includ	le.			the facility took to correct the deficient practice for any client		
	During on inter	niow on 7/10/2012 of			the facility identified as being		
	•	view on 7/10/2013 at			affected. Facility audited all		
		esident #18 stated, "I			current residents' safety device	es	
	• .	pain Last Monday			to ensure accuracy and appropriateness. All aide		
	•	ng me off the bed to put			assignment sheets were revise	ed.	
		el chair. I have to slip			with updated safety device		
		en their arms so they			information including the		
		and turn me around			appropriate and safe way to		
		he chair. They sat me			transfer each resident. 3.		
		the chair and she let			Describe the steps or systemic changes the facility has made		
	-	he other CNA [Certified			will make to ensure that the	01	
	_	ant] had a hold of me.			deficient practice does not rec	ur,	
	_	out of the chair. I			including any in-services, but t		
	•	as sliding out of my			also should include any system		
	•	ust stood there. [CNA			changes you made. The nursi staff will be in-serviced on	ng	
	-	s trying to pull me up in			following the transfer technique	es	
	the chair and I	told her, 'Young lady			appropriately and safely and		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLI	ETED
		155378	B. WIN			07/18/2013	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	₹		1	GRANT ST		
SIGNATI	URE HEALTHCARE	E AT PARKWOOD			ON, IN 46052		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	<u> </u>	R LSC IDENTIFYING INFORMATION)		TAG			DATE
	_	and help [CNA #9			using appropriate safety deviction for each resident by the SDC of		
		e up. She can't do it			8/2, 8/5, and 8/6/2013. This wi		
		ne just stood there. I			include where to find the		
		because I fell and she			appropriate information. The		
	-	evented it I hurt my			managers will complete an au	dit	
	•	t day it started hurting			daily of all safety devices and		
		They gave me pain			ensure that CNA assignment sheets are up to date with corr	rect	
	pills and it help	ed." Resident #18			transfer and safety device	CCI	
	pointed to her	left stump.			information (see Attachment G	;	
					included with 2567 front page		
	During an inter	view on 7/16/2013 at			fax). 4. Describe how the		
	10:10 A.M., the DON indicated				corrective action(s) will be monitored to ensure the deficient	ont	
	Resident #18 r	reported concerns			practice will not recur, i.e., what		
	regarding the t	ransfer assisted by NA			quality assurance program wil		
	(Nurses Aide)	#8 the day after it			put into place. The results of the		
	happened. As	a result NA #8 was			audits will be forwarded to the		
		e clarified the incident			monthly Quality Assurance		
	occurred on Ju	ıly 6, 2013, not on			Meeting for further review and recommendation. The audits v		
		8, 2013) as the resident			continue daily for 30 days, we		
		further indicated			for 30 days and then monthly		
		was "95% reliable".			for 6 months in order to ensure	е	
					continued compliance.		
	During a phone	e interview on					
	• •	1:50 A.M., terminated					
		"This was my first job					
		naven't even taken my					
		s my day off and they					
		hour and a half before					
		se they were short. I					
		ose residents. Yes, I					
		ment sheet but					
	_	named] was not my					
	-	in't take the time to look					
	•						
		answered the call light					
	i and told her i d	could not get her up on					

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Event ID: 53YG11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378			(X2) MULTIPI A. BUILDING B. WING	E CONSTRUCTION 00		DATE SURVEY COMPLETED 07/18/2013
	PROVIDER OR SUPPLIE		STR 100	EET ADDRESS, CITY, STATI 11 N GRANT ST BANON, IN 46052	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE A CROSS-REFERENCED	TO THE APPROPRIATE	(X5) COMPLETION DATE
	nurse. She sameds [medicar have to wait. the floor Motwo staff to get by myself. If shurt herself the been in trouble the lift. We sathe bed, put or and transferred. During an intermedited to an administrator, present, LPNf needed" pain administered, be noted on the gave it, the intermediate see if it was eff number scale. Resident #18's 7/15/2013 at 9 diagnoses, who not limited to, amputee, diab to her right low. A current care indicated Resi with a history of the staff of t	rview on 7/17/2013 at				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S	ETED	
		155378	B. WIN			07/18/	2013
NAME OF P	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE GRANT ST		
	JRE HEALTHCARE	E AT PARKWOOD			ON, IN 46052		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	and pain. To i	ncrease safe transfers, ansfer her with a					
	indicated Resid	ders dated 2/15/12, dent #18 had an order ICL 50 Milligrams four pain.					
	indicated Resid	ders, dated 6/28/12, dent #18 had Tylenol three times daily for					
	indicated Residers for Hydronicate (narcotic pain in Milligrams every Vicodin (Hydronicate)	ders, dated 3/6/12, dent #18 had routine rocodone-APAP reliever) 5/500 ry evening for pain and ocodone-APAP) 5/500 ry 4 hours as needed					
	June 1, 2013 the Documentation	were reviewed from hrough July 6, 2013. n indicated, throughout esident #18 denied fort.					
	A.M., indicated reported her cumedications we	dated 7/6/2013-6:00 I, Resident #18 urrent scheduled pain ere effective in chronic pain issues.					

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STATEMENT OF D	DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN OF CO	RRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155378	B. WIN			07/18/	2013
			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVID	DER OR SUPPLIER			1001 N	GRANT ST		
SIGNATURE H	HEALTHCARE	AT PARKWOOD		LEBAN	ON, IN 46052		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
	-	June 2013, Medication					
		Records [MAR]					
ind	indicated, Resident #18 took the "as needed" Vicodin once during these two months.						
nee							
two							
An	nurse's note	dated 7/7/13-7:00					
		, "Reports pain in L					
		evening. Reports it					
-	s ached all d						
liac	s acrica an a	ау					
The	a MAD for I	uly 2013, indicated					
		eceived an "as					
		n on July 7th at 11:00					
A.N	VI.						
	•	view on 7/18/2013 at					
6:4	7 A.M., the [DON indicated, the					
nur	rse who gave	e Resident #18 the "as					
nee	eded" pain m	nedication on July 7,					
201	13 contacted	her and informed her					
she	e gave the a	dditional pain medicine					
	"back and le	-					
	2231. 4114 10	.a.e					
31	-45(a)(2)						
	10(4)(2)						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155378	B. WIN			07/18/	2013
			D. ((1)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				GRANT ST		
SIGNATI	JRE HEALTHCARE	AT PARKWOOD			ON, IN 46052		
					T		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
F000362	483.35(b)	TARY CURRORT					
SS=E	PERSONNEL	TARY SUPPORT					
		employ sufficient support					
		tent to carry out the					
	functions of the d						
		rvation, interview, and	F00	0362	F362-Sufficient Dietary Suppo	ort	08/17/2013
		the facility failed to			Personnel: 1. Describe what		
	-	ere sufficient dietary			facility did to correct the deficie		
		ensure meals were			practice for each client cited in		
	served timely for				the deficiency. Effective 7/15/		
	•	•			facility revised serving times a		
	observations a				staff allocation to ensure 2 staff members are available in the	П	
		wed regarding food			main dining room 15 minutes		
	quality and ser	vice.			prior to serving time to pass all	1	
					drinks and serve trays timely.		
	Findings includ	e:			Describe how the facility		
					reviewed all clients in the facili	ty	
	On 7/9/2013 at	: 11:30 A.M., an			that could be affected by the		
	observation of	a sign posted by the			same deficient practice, and		
		e dining area was			state, what actions the facility took to correct the deficient		
		n indicated, breakfast			practice for any client the facili	tv	
	_	8:15 A.M., lunch was			identified as being affected.	-,	
		5 P.M., and dinner was			Effective 7/15/13, facility revise	ed	
	served at 6:15	•			serving times for all dining area	as	
	Sciveu at 0.15	ı .ivi.			and staff allocation to ensure		
	Canatant abou	mustians was made of			enough staff in each serving a	rea	
		rvations were made of			to provide food timely. 3.		
		Cafe dining room on			Describe the steps or systemic changes the facility has made		
	_	nning at 12:24 P.M.			will make to ensure that the	01	
	and ending at 1				deficient practice does not reci	ur,	
	following obser	vations were made:			including any in-services, but t		
					also should include any system	n	
	12:24 P.M 16	residents seated in			changes you made. Facility		
	the dining room	n waiting to be served.			in-serviced nursing and dietary		
	No food being				staff on 7/12/13, to educate sta	ат	
	_	e staff offering only			on new dining plan. Serving times were revised for accuracy	·V	
		his time. She indicated			and staff was re-assigned to	, y	
		ino unio. One mulcateu			and otall was to assigned to		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155378	B. WIN			07/18/2013
		l .	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	L			GRANT ST	
SIGNATU	JRE HEALTHCARE	AT PARKWOOD			ON, IN 46052	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
	she would com	e back and provide the			different areas to ensure enou	gh
hot drinks when she was done. Carts				staff in each location to provide	9	
	being filled with	n trays of food to be			residents timely meal	
	_	areas in the facility.			service. The Dietician or desig	
		st person in the room			will complete an audit of the m service 3x daily for first 2 week	
	was offered a	-			1x daily for next 2 weeks, then	
		sidents who wanted hot			weekly for 30 days, then 1x	-
					weekly for 30 days. This will	
		rved hot drinks.			include timeliness of meals be	
		st resident who wanted			served, food temps and intervi	ew
		s served his drink.			of 3 residents each day	-4 :
		t tray delivered to a			alternating the resident who eather the dining room and the reside	
		is time, two staff			who eat in their room (see	111
	observed servi	ng trays.			Attachment I included with 256	§7
	1254 P.M sed	cond tray served to a			front page fax). The resident	
	resident				council minutes will be reviewe	ed .
	12:56 P.M Re	esident yelled out,			by the Administrator and Dietic	
	"Where is the f	ood." Staff responded,			following the meeting to ensure	e
		e are running behind."			timely follow up of dietary concerns. 4. Describe how the	20
	_	f [now] 20 residents			corrective action(s) will be	
		ning room had not			monitored to ensure the deficie	ent
	been served lu	•			practice will not recur, i.e., wha	
		residents not served			quality assurance program will	
	lunch				put into place. The results of the audits will be forwarded to the	ie
		sidents still not served			monthly Quality Assurance	
	lunch.				Meeting for further review and	
		sident A was served ice			recommendation. The audits v	<i>r</i> ill
		emoved the lid when			continue three times weekly fo	
		The ice cream was			30 days then weekly for 30day	
	melted almost				and then monthly for 6 months ensure continued compliance.	iO
		io liquid. sident A was asked if			choure continued compilation.	
		cream melted. He				
	•	t it's that way by the				
	time it gets her					
		last resident in the				
	room was serv	ed lunch				

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155378	B. WIN	G		07/18/	2013
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	NO VIDEN ON SOITEEL	•			GRANT ST		
SIGNATU	JRE HEALTHCARE	E AT PARKWOOD		LEBAN	ON, IN 46052		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
TAG	During observation 12:42 P.M., statice cream that consistency. Fit is liquid again Interviews with 7/9/2013 at 11 indicated, at tirk Her toast was ate a lot of peasandwiches be not so good. 7/9/2013 at 12 indicated, her fit than it was not 7/9/2013 at 12 stated, "cold is by the time the drink the ice cretoday. Pretendon if you like well have not eate cold or too hot been cold."	ations on 7/10/2013 at aff served Resident A was near liquid Resident A stated, "Yes, in today." Tresidents and family: 1:50 A.M., Resident P mes her food is cold. usually burned and she anut butter and jelly ecause the food was 1:05 P.M., Resident N food was cold more		TAG	DEFICIENCY)		DATE
	setting up trays	e serving, cutting, and s. They need wear We are					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378	A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPI 07/18	
		100070	B. WIN			0//10	12013
NAME OF P	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE GRANT ST		
SIGNATU	JRE HEALTHCARE	E AT PARKWOOD			ON, IN 46052		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDENCE N. AN OF CORRECTIV	W.	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		e served at 12:15. I					
	come down he	re at 12:00 ."					
	7/0/2012 1:22	P.M Resident B's					
		stated, "He has been					
	•	30 A.M., He didn't					
		itil after 1:00 today.					
	_	g Sometimes he gets					
		e will wheel himself					
	_	m without eating. He					
	has done that	several times"					
		28 P.M., Resident E					
	•	Is were served late and					
	, ,	of the time she didn't					
	get what she o	rdered.					
	7/10/2013 0:58	5 A.M., Resident F					
		t of the time the food					
	•	zing. It was continually					
		ly late because there					
	was not enoug	•					
	7/10/2013 -10:	28 A.M Resident D					
	stated, "I eat in	my room. Sometimes					
	it is cold. No ce	ertain meal. It depends					
	on how long it	takes to get here and					
		when it leaves the					
		ice cream is usually					
	pretty soft whe	n I get it"					
	7/40/40 = 1.40 4	14 A M - \M/han aals st					
		I4 A.M., When asked if					
		good and looked					
		sident G replied, "It e cream is like a					
	Sucks. The ICE	CIEAIII IS IIKE A					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155378	B. WIN	G		07/18/	/2013
NAME OF F	PROVIDER OR SUPPLIE	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					GRANT ST		
SIGNATI	JRE HEALTHCAR	E AT PARKWOOD		LEBAN	ON, IN 46052		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
TAG		s drinkable I am so	+	TAG			DATE
		h the food, I don't eat					
		every body." He further					
	indicated the food was not served at proper temperatures and his family						
		-					
	had to bring him food from the outside.						
	outoido:						
	7/10/2013 at 1	1:21 A.M., Resident I					
		and a while there was					
	not enough sta	aff to serve trays and it					
	happened aga	-					
		:49 A.M., When asked					
		served at the proper					
		Resident H responded,					
		coldeveryday its cold."					
	7/10/2013 at 1	0:05 A.M., Resident K					
	indicated she	ate in the dining room.					
	Her eggs were	sometimes cold. She					
	had to wait a lo	ong time to be served					
	at all meals. S	She further indicated					
	she felt it was	sometimes due to staff					
		ir job seriously" and					
		eir was just not enough					
	staff down the	re."					
		400 444 5 11 15					
		1:38 A.M., Resident O					
		nad to wait up to an					
		ved at times in the					
	dining room.						
	7/10/2013 at 1	:57 D.M. Desident M					
		:57 P.M., Resident M					
	· ·	ite in his room and food was cold.					
	sometimes his	1000 was cold.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378		ĺ	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155378	B. WIN			07/18/2013
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE GRANT ST	
SIGNATI	JRE HEALTHCARE	AT PARKWOOD			ON, IN 46052	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
	7/11/2013 at 1: stated, "The for the chef. It is of 7/15/2013 at 8: was observed of this time she in wasn't any bett eggs were cold Interview with f 7/9/2013 at 1:3 #14 stated, "It I The start times enough help in office is suppos don't Staff w to pick up there residents are s eat Somethin 7/15/2013 at 9: #13 indicated, with the food b times had to do servers and ge kitchen. 7/15/2013 at 9: Manager stated having to page here to help pa	14 PM, Resident F od is awful. I spoke to coldand no variety." 41 A.M., Resident F eating breakfast. At dicated, her food er today because her I again.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 53YG11

Facility ID: 000468

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155378	B. WING		07/18/2013	
NAME OF I	PROVIDER OR SUPPLIEI	₹		ADDRESS, CITY, STATE, ZIP CODE		
CICNIAT	IDE LIEAL TUCAS			GRANT ST		
	JRE HEALTHCARE			ION, IN 46052		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
TAG		last week. We were	TAG	DEFICE NO. 1	DATE	
	•	so we run behind a little				
	•	catch up and then we				
	1	nd wait for staff to pass				
		d is hot when it goes				
	out because w	•				
		but by the time it goes				
		probably is cold, and				
		on residents are				
	complaining."					
	Resident Cour	ncil Minutes were				
	reviewed for th	e months of January				
	2013 through .	June 2013. The				
		bruary 2013, indicated,				
		nere "was not enough				
		The minutes for				
		dicated, Residents felt				
		o be more staff. The				
	-	ril 2013, indicated,				
		complaints of "food not				
	_	ough" and "wait times				
		e minutes for May				
	1	d, Residents had				
		he "food not always				
	_	igh", the "ice cream is				
	at times."	s", and "meals are late				
	at times.					
	During an inter	view on 7/16/2013 at				
	_	Administrator indicated				
	· ·	uality Assessment				
		d identified concerns				
		and residents having to				
		ds of time to be served				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 53YG11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2013 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 155378	A. BUILDING B. WING	00	COMPLE 07/18/2	ETED
	PROVIDER OR SUPPLIER JRE HEALTHCARE AT PARKWOOD	1001 N	ADDRESS, CITY, STATE, ZIP CO GRANT ST ON, IN 46052	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	meals through observations and the Resident Council Minutes. She indicated the Resident Council Minutes in March alluded to problems with cold food and wait times, however, audits had not been started until July 1, 2013, to address the concerns. This Federal tag relates to Complaint IN00131013. 3.1-20(h)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 53YG11

Facility ID: 000468

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIM DDIG	00	COMPLETED	
		155378	A. BUILDING		07/18/2013	
			B. WING	ADDRESS CITY STATE ZIR CODE		
NAME OF P	ROVIDER OR SUPPLIER	2		ADDRESS, CITY, STATE, ZIP CODE		
CIONATI				I GRANT ST		
SIGNATO	JRE HEALTHCARE	E AT PARKWOOD	LEBAN	ION, IN 46052		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F000364	483.35(d)(1)-(2)					
SS=E	NUTRITIVE VAL	UE/APPEAR,				
	PALATABLE/PRI	EFER TEMP				
		ceives and the facility				
		epared by methods that				
		e value, flavor, and				
		food that is palatable,				
		the proper temperature.	700055		00.11-12-12	
		ervation, interview, and	F000364	F364-Nutritive Value/Appear,	08/17/2013	
	record review,	the facility failed to		Palatable/Prefer Temp: 1.		
	provide resider	nts food that was		Describe what the facility did to		
	palatable and s	served at appropriate		correct the deficient practice for		
	•	or 16 of 23 residents		each client cited in the deficient Effective 7/15/13, facility revise	·	
	reviewed for fo			serving times and staff allocat		
	Teviewed for to	od quanty.		to ensure 2 staff members are		
				available in the main dining ro		
	Findings includ	ie:		15 minutes prior to serving tim	l l	
				to pass all drinks and serve tra	l l	
	On 7/9/2013 at	t 11:30 A.M., an		timely to ensure appropriate for	ood	
	observation of	a sign posted by the		temperatures. 2. Describe h	now	
	Rosewood Caf	e dining area was		the facility reviewed all clients	l l	
		n indicated, breakfast		the facility that could be affect		
	_	8:15 A.M., lunch was		by the same deficient practice		
		·		and state, what actions the fac	cility	
		5 P.M., and dinner was		took to correct the deficient	:4.	
	served at 6:15	P.M.		practice for any client the facil	ity	
				identified as being affected. Effective 7/15/13, facility revis	ed	
	Constant obse	rvations were made of		serving times for all dining are		
	the Rosewood	Cafe dining room on		and staff allocation to ensure		
	7/9/2013, begir	nning at 12:24 P.M.		enough staff in each serving a	irea	
	_	1:25 P.M. The		to provide food timely and to		
	_	rvations were made:		ensure appropriate food		
	IOIIOWING ODSEI	valions were made.		temperatures. 3. Describe th	e	
	40.04 D.M. 40	manislanda anata dia		steps or systemic changes the		
		residents seated in		facility has made or will make		
	_	n waiting to be served.		ensure that the deficient pract	ice	
	No food being	served.		does not recur, including any		
	12:31 P.M on	e staff offering only		in-services, but this also shou		
		his time. She indicated		include any system changes y	ou	
		ino timo. Ono maioatea	1	made. Dietary staff to be		

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Event ID: 53YG11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLETED
		155378	B. WIN			07/18/2013
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	L			GRANT ST	
SIGNATU	JRE HEALTHCARE	AT PARKWOOD			ON, IN 46052	
(V4) ID	CLIMMA DAY C	TATEMENT OF DESIGNATES		ID	, I	(V5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	DATE
1710		· · · · · · · · · · · · · · · · · · ·	+	1710	educated, on 7/31/13, about the	
		e back and provide the			need for meal service to be time	l l
hot drinks when she was done. Carts				to ensure food stays at proper		
	_	n trays of food to be			temperature. Staff also educa	ted
		areas in the facility.			about the need to ice down all	l l
		st person in the room			cold foods, including ice crean	
	was offered a				to ensure food stays at proper	
	12:39 P.M res	sidents who wanted hot			temperature. The Dietician or designee will complete an aud	it of
	drinks were se	rved hot drinks.			the meal service 3x daily for fir	
	12:50 P.M las	st resident who wanted			2 weeks, 1x daily for next 2	·
	a hot drink was	s served his drink.			weeks, then 3x weekly for 30	
	12:52 P.Mfirst tray delivered to a				days, then 1x weekly for 30 da	ys.
	resident. At this time, two staff				This will include timeliness of	
	observed servi				meals being served, food temp	
		cond tray served to a			and interview of 3 residents ea	
	resident	ond tray served to a			day alternating the resident wheat in the dining room and the	10
		soidant vallad aut			resident who eat in their room	
		esident yelled out,			(see Attachment I included wit	h
		ood." Staff responded,			2567 front page fax). The	
	_	e are running behind."			resident council minutes will be	e
		f [now] 20 residents			reviewed by the Administrator	l l
		ning room had not			Dietician following the meeting	
	been served lu	nch.			ensure timely follow up of dieta concerns. 4. Describe how the	•
	1:10 P.M 10 r	esidents not served			corrective action(s) will be	
	lunch				monitored to ensure the deficie	ent
	1:16 P.M 5 re	sidents still not served			practice will not recur, i.e., wha	
	lunch.				quality assurance program will	l l
	1:17 P.M Res	ident A was served ice			put into place. The results of the	ne
		emoved the lid when			audits will be forwarded to the	
		he ice cream was			monthly Quality Assurance Meeting for further review and	
	melted almost				recommendation. The audits v	_{rill}
		sident A was asked if			continue three times a weekly	
		cream melted. He			30 days then weekly for 30 day	
					and then monthly for 6 months	
	1	t it's that way by the			ensure continued compliance.	
	time it gets her					
		last resident in the				
	room was serv	ed lunch				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155378	B. WIN	IG		07/18/	2013
NAME OF P	ROVIDER OR SUPPLIER	· ?			ADDRESS, CITY, STATE, ZIP CODE		
					GRANT ST		
SIGNATU	JRE HEALTHCARE	E AT PARKWOOD		LEBAN	ON, IN 46052		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	During observa	ations on 7/10/2013 at					
	12:42 P.M., staff served Resident A ice cream that was near liquid consistency. Resident A stated, "Yes, it is liquid again today."						
	Interviews with	residents and family:					
	7/9/2013 at 11	:50 A.M., Resident P					
		mes her food is cold.					
	Her toast was	usually burned and she					
	ate a lot of pea	anut butter and jelly					
	sandwiches be	ecause the food was					
	not so good.						
	7/0/2013 at 12	:05 P.M., Resident N					
		food was cold more					
	than it was not						
	than it was not						
	7/9/2013 at 12	:15 P.M., Resident L					
	stated, "cold is	warm and hot is warm					
	by the time the	ey get it too you You					
		ream. It was that way					
	,	d it is a shake and go					
	_	arm ice cream Yes,					
		en because it was too					
		when it should have					
	been cold."						
	7/9/2013-12:30	P.MResident C					
	stated, "There	is usually only one or					
	two staff in her	e serving, cutting, and					
	setting up trays	s. They need					
	something. Is	wear We are					

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Event ID: 53YG11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPI 07/18		
		100070	B. WIN			0//10	12013
NAME OF P	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE GRANT ST		
SIGNATU	JRE HEALTHCARE	E AT PARKWOOD			ON, IN 46052		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDENCE N. AN OF CORRECTIV	W.	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		e served at 12:15. I					
	come down he	re at 12:00 ."					
	7/0/2012 1:22	P.M Resident B's					
		stated, "He has been					
	•	30 A.M., He didn't					
		itil after 1:00 today.					
	_	g Sometimes he gets					
		e will wheel himself					
	_	m without eating. He					
	has done that	several times"					
		28 P.M., Resident E					
	•	Is were served late and					
	, ,	of the time she didn't					
	get what she o	rdered.					
	7/10/2013 0:58	5 A.M., Resident F					
		t of the time the food					
	•	zing. It was continually					
		ly late because there					
	was not enoug	•					
	7/10/2013 -10:	28 A.M Resident D					
	stated, "I eat in	my room. Sometimes					
	it is cold. No ce	ertain meal. It depends					
	on how long it	takes to get here and					
		when it leaves the					
		ice cream is usually					
	pretty soft whe	n I get it"					
	7/40/40 = 1.40 4	14 A M - \M/han aals st					
		I4 A.M., When asked if					
		good and looked					
		sident G replied, "It e cream is like a					
	Sucks. The ICE	CIEAIII IS IIKE A					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155378	B. WIN	NG		07/18/	2013
NAME OF P	PROVIDER OR SUPPLIEI	3	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					GRANT ST		
SIGNATU	JRE HEALTHCARE	E AT PARKWOOD		LEBAN	ON, IN 46052		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		s drinkable I am so					
	•	h the food, I don't eat					
	itI have told every body." He further						
		ood was not served at					
	1 ' ' '	atures and his family					
		m food from the					
	outside.						
	7/10/2013 at 1	1:21 A.M., Resident I					
		and a while there was					
		aff to serve trays and it					
	happened aga						
		:49 A.M., When asked					
		served at the proper					
		Resident H responded,					
		coldeveryday its cold."					
		ionamoron y a a y morocian					
	7/10/2013 at 1	0:05 A.M., Resident K					
		ate in the dining room.					
		sometimes cold. She					
	••	ong time to be served					
		She further indicated					
	she felt it was	sometimes due to staff					
	"not taking the	ir job seriously" and					
	"sometimes the	eir was just not enough					
	staff down thei	re."					
	7/10/2013 at 1	1:38 A.M., Resident O					
		nad to wait up to an					
	hour to be serv	ved at times in the					
	dining room.						
		:57 P.M., Resident M					
	I	ite in his room and					
	sometimes his	food was cold.	\perp				

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Event ID: 53YG11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Ì	ULTIPLE CO	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155378	B. WIN			07/18/2013
NAME OF P	ROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE	
SIGNATU	JRE HEALTHCARE	AT PARKWOOD			ON, IN 46052	
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
TAG	7/11/2013 at 1: stated, "The for the chef. It is of the chef. It is of 7/15/2013 at 8: was observed of this time she in wasn't any bett eggs were cold. Interview with for 7/9/2013 at 1:3 #14 stated, "It I The start times enough help in office is suppost don't Staff what to pick up there residents are sheat Somethin 7/15/2013 at 9: #13 indicated, with the food bettimes had to do servers and get kitchen. 7/15/2013 at 9: Manager stated having to page	14 PM, Resident F od is awful. I spoke to coldand no variety." 41 A.M., Resident F eating breakfast. At dicated, her food er today because her I again.		TAG	DEFICIENCY)	DATE
1	staffed in the k	itchen Four people				

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Event ID: 53YG11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE :	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155378	B. WIN			07/18/	2013
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
OLONIATI	IDE LIEAL TUGA DE	AT DADIMACOD			GRANT ST		
SIGNATO	JRE HEALTHCARE	AT PARKWOOD		LEBANG	ON, IN 46052		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+-	TAG	DEFICIENC!)		DATE
		last week. We were					
	•	o we run behind a little					
	_	catch up and then we					
		nd wait for staff to pass					
	_	l is hot when it goes					
	out because w	-					
		but by the time it goes robably is cold, and					
		on residents are					
	complaining."	on residents are					
	Complaining.						
	Resident Coun	cil Minutes were					
		e months of January					
		lune 2013. The					
	_	bruary 2013, indicated,					
		ere "was not enough					
		The minutes for					
		dicated, Residents felt					
		o be more staff. The					
		ril 2013, indicated,					
	•	complaints of "food not					
		ough" and "wait times					
	~	e minutes for May					
		d, Residents had					
	•	he "food not always					
	•	gh", the "ice cream is					
	_	s", and "meals are late					
	at times."	, , , , , , , , , , , , , , , , , , , ,					
	_						
	During an inter	view on 7/16/2013 at					
		Administrator indicated					
	·	uality Assessment					
		d identified concerns					
	with cold food	and residents having to					
		ds of time to be served					

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Event ID: 53YG11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 155378	(X2) MULTIPLE CO A. BUILDING B. WING	00				
	PROVIDER OR SUPPLIER URE HEALTHCARE AT PARKWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	meals through observations and the Resident Council Minutes. She indicated the Resident Council Minutes in March alluded to problems with cold food and wait times, however, audits had not been started until July 1, 2013, to address the concerns. This Federal tag relates to Complaint IN00131013. 3.1-21(a)(2)						

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155378	B. WINC			07/18/	2013
			1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				GRANT ST		
SIGNATI	JRE HEALTHCARE	AT PARKWOOD			ON, IN 46052		
					014, 114 40002		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL] 1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG F000406 SS=D	483.45(a) PROVIDE/OBTAI SERVICES If specialized rehabut not limited to, speech-language therapy, and menservices for mentretardation, are recomprehensive provide the required services (in accordance wifrom a provider of services. Based on obseand interview, for provide special services for 2 cowith diagnoses (Resident #95 and 1. Resident #95 a	IN SPECIALIZED REHAB abilitative services such as, physical therapy, pathology, occupational stal health rehabilitative al illness and mental equired in the resident's lan of care, the facility must red services; or obtain the from an outside resource ith §483.75(h) of this part) if specialized rehabilitative ervation, record review, the facility failed to lized rehabilitative of 2 residents reviewed of mental retardation and Resident #5).	F000	TAG	F406-Provide/Obtain Specializ Rehab Services (Level II): 1. Describe what the facility did to correct the deficient practice for each client cited in the deficient Resident #95's Level II Pre-Admission screening was initiated on 7/15/13 to correct deficient practice. Resident #8 was referred to PT, OT, ST for screening on 8/2/13. Resident	zed or or ocy.	DATE 08/17/2013
	facility on 3/3/1	3 and had a diagnoses mental retardation.			has been referred to all ancilla services (optometry, audiology dental, and medical). Residen #5 is being re-assessed for	′,	
	1:36 P.M., the Designee was Resident #95's Screening and Review.	view on 7/15/2013 at Social Service asked to provide Level II Pre-Admission Annual Resident view on 7/16/2013 at Administrator indicated			one-on-one activities to meet he SRS needs. 2. Describe how the facility reviewed all clients the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility dentified as being affected. Facility will audit all current residents to ensure that Level Pre-Admission screenings are	w in ed :ility ty	

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Event ID: 53YG11

Facility ID: 000468

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLETED
		155378	B. WIN			07/18/2013
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	R			GRANT ST	
SIGNATI	JRE HEALTHCARE	AT PARKWOOD			ON, IN 46052	
					O14, 114 40032	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	· ·	DATE
		Pre-Admission			initiated for residents who mee criteria and will ensure that all	E
	_	Annual Resident			SRS recommendations are be	ina
	Review could r	not be located.			followed. 3. Describe the step	•
					or systemic changes the facilit	
	During an inter	view on 7/18/2013 at			has made or will make to ensu	-
	9:46 A.M., with	Social Service (SS)			that the deficient practice does	3
		SS Employee #3, and			not recur, including any	
		al Service Director)			in-services, but this also shoul	
	,	nployee #2 indicated,			include any system changes y made. The Social Service	Ou
	l '	evel II screening was			Department, the Business Offi	ce
		for Resident #95			and the Admissions Departme	
		he was originally			were in-serviced by the	
		•			Administrator on Level II	
		as supposed to only be			completion on 8/6/2013. The	
		ey had intended for			Social Service Department wa	
		the group home			in-serviced by the Administrato	or
		previously. She			on following SRS recommendation for the MRDI	n
		ed, the required Level II			resident in the facility on	
	screening shou	uld have been initiated			8/5/2013. The Administrator	or
	after his stay e	xtended past 30 days.			designee will monitor level II	
					completion and SRS	
	2. On 7/10/20	13 at 1:36 P.M. and			recommendation completion	
	7/11/2013 at 1	:30 P.M., Resident #5			weekly (see Attachment J	
		sitting in a room across			included with 2567 front page fax). 4. Describe how the	
		ng station by himself.			corrective action(s) will be	
		open and he was			monitored to ensure the deficie	ent
		s hands and making			practice will not recur, i.e., wha	at
	1	e was a television on in			quality assurance program will	I
					put into place. The results of t	he
		channel with soap			audits will be forwarded to the	
	operas.				monthly Quality Assurance Meeting for further review and	
		7/15/00/10			recommendation. The audits w	II
	1	view on 7/15/2013 at			continue weekly for 30 days th	
	1	Social Service			monthly for 6 months to ensure	
	•	asked to provide			continued compliance.	
	Resident #5's	Level II Pre-Admission				
	Screening.					

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Event ID: 53YG11

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PRINTED: 09/03/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	00	COMPL	
DIE		155378		LDING		07/18/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	3.7.107	
NAME OF P	PROVIDER OR SUPPLIER				GRANT ST		
SIGNATU	JRE HEALTHCARE	AT PARKWOOD			ON, IN 46052		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFFING INFORMATION)		IAG	BEFFEERET		DATE
	On 7/16/2013 <i>(</i>	at 9:24 A.M., the					
		provided Resident #5's					
		plan. Resident #5's					
		dicated, Resident #5					
	•	el II on 2/28/2013. He					
		nental disability and					
	·	ew in one year. He					
	•	alized Rehabilitation					
		for a developmental					
	, ,	lid meet the PASSAR					
	Level II criteria						
		nursing facility for					
		es for medical needs.					
	_	s included habilitation					
		ational therapy,					
		y, speech/language					
		ition/leisure activities,					
		evaluations or exams					
		utine optometry,					
	•	tal and medical follow					
	along.	tar arra rricatoar tonow					
	, a.o.i.g.						
	During an inter	view on 7/17/2017 at					
		istered Nurse #5 was					
	asked what the						
		Registered Nurse #5					
		think much. He sits in					
	,	watches TV or he is in					
	his bed. I don'						
	comprehends a						
	Compronding (~··, ··································					
	During an inte	rview on 7/17/2013 at					
	_	Director of Nursing					
	(DON) was ask	_					
	, 11112 201	- 1					

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Event ID: 53YG11

Facility ID: 000468

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155378	B. WIN			07/18/	2013
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
SIGNATI	JRE HEALTHCARE	AT PARKWOOD			GRANT ST ON, IN 46052		
							(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	documentation	of the services being					
		sident #5 according to					
	his Level II Pre	-Admission-Screening					
	Plan.						
	_	view on 7/18/2013 at					
		Social Service (SS)					
		SS Employee #3, and					
	•	nt, the SSD indicated,					
		ed that Resident #5 ing in front of the TV.					
	, ,	e facility had not					
	provided Resid	•					
		r speech/language					
	·	es. The SSD further					
		acility did not have an					
		re plan in place which					
		ements of Resident					
	#5's rehabilitati	ion plan and					
	programing ne	eds.					
	3.1-23(a)(1)						

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Event ID: 53YG11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155378	B. WING		07/18/2013
			STREET	ADDRESS, CITY, STATE, ZIP CODE	I.
NAME OF F	PROVIDER OR SUPPLIE	₹		GRANT ST	
SIGNATU	JRE HEALTHCAR	E AT PARKWOOD		ION, IN 46052	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F000431 SS=E	483.60(b), (d), (e) DRUG RECORD & BIOLOGICALS The facility must services of a lice establishes a sys and disposition of sufficient detail to reconciliation; an records are in or all controlled dru- periodically recon- Drugs and biolog- must be labeled accepted profess include the appro- cautionary instru- date when applied In accordance with facility must se biologicals in local proper temperatural authorized person keys. The facility must permanently affines storage of control Schedule II of the Abuse Prevention and other drugs se when the facility drug distribution quantity stored is dose can be reace Based on obse record review, ensure refriger	employ or obtain the nsed pharmacist who stem of records of receipt of all controlled drugs in the enable an accurate of determines that drug der and that an account of the grain accordance with currently sional principles, and principles, and principles, and the expiration exable. Ith State and Federal laws, store all drugs and exed compartments under the controls, and permit only nnel to have access to the expiration of the compartments for example of the compartments of the expiration of the expiration of the compartments of the expiration of the expiration of the expiration of the expiration of the expiration, and the facility failed to the expiration, interview, and the facility failed to exators which stored	F000431	F431-Drug Records, Label/St Drugs & Biologicals: 1. Desc what the facility did to correct deficient practice for each clie	ore 08/17/2013 ribe the
	resident medic	ation were monitored		cited in the deficiency. Facility	

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Event ID: 53YG11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJI	DING	00	COMPLI	ETED
		155378	1	LDING		07/18/	2013
			B. WIN		ADDRESS OF STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
CLONIATI		- 17 010/000			GRANT ST		
SIGNATI	JRE HEALTHCARE	E AT PARKWOOD		LEBAN	ON, IN 46052		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	for accurate te	mperatures for 1 of 9			added missing temperature log		
	medication refi	rigerators utilized in the			Maplewood refrigerator effecti		
	facility.				July 17, 2013. 2. Describe he		
	l admity.				the facility reviewed all clients		
	Findings includ	امط			the facility that could be affected		
	Findings include	ieu.			by the same deficient practice and state, what actions the fac		
		4.40.544			took to correct the deficient	inty	
	On 7/17/13 at	•			practice for any client the facili	tv I	
		the medication			identified as being affected.		
	refrigerator loc	ated on the Maplewood			refrigerators which store reside		
	unit was obser	ved to contain			medications will be audited an	d	
	Lorazepam, TE	3 serum, Biscodyl			monitored to ensure temperate	ıre	
	-	Lantus insulin, Novalog			logs are available and complet		
	insulin, and Va	•			daily. 3. Describe the steps o		
		-			systemic changes the facility h		
	,	travenous). At this time			made or will make to ensure the		
	,	ctor of Nursing) was			the deficient practice does not		
		de documentation			recur, including any in-services but this also should include an		
	which indicated	d the refrigerator			system changes you made. A	-	
	temperatures v	were being monitored.			staff has been in-serviced		
					regarding storage of medication	ns	
	During an inter	view on 7/17/13 at			and refrigerator temperature lo		
	_	DON (Director of			by the SDC on 8/2, 8/5, and		
	Nursing) indica	•			8/6/2013. All refrigerators wh	ich	
	· · · · · · · · · · · · · · · · · · ·				store medications will be		
	1	hich stored medications			monitored daily by the unit		
	were required	•			managers (see Attachment K		
	_	emperatures. She			included with 2567 front page		
	further indicate	ed she was unable to			fax). 4. Describe how the corrective action(s) will be		
	provide docum	entation which			monitored to ensure the deficient	ent	
	indicated the n	nedication refrigerator			practice will not recur, i.e., wha		
		itored for accurate			quality assurance program will		
	temperatures.	 			put into place. The results of t		
	l simporataros.				audits will be forwarded to the		
	A aumant malin	v titled "Sterees of			monthly Quality Assurance		
		y titled, "Storage of			Meeting for further review and		
		and dated 10/31/09,			recommendation. The audits v		
		e Administrator on			continue daily for 30 days ther	1	
	7/18/13 at 8:00	A.M., indicated,			weekly for 30 days and then		

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Event ID: 53YG11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE : COMPL		
155378			LDING		07/18/		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				GRANT ST		
SIGNATU	JRE HEALTHCARE	AT PARKWOOD			ON, IN 46052		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		ations requiring	+	TAG	monthly for 6 months to ensur		DATE
	-	or "temperatures			continued compliance.		
	_	rees Celsius (36					
	_	nheit) and 8 degrees					
	_	grees Fahrenheit)" in a					
		h a thermometer to					
	-	ure monitoring"					
		view on 7/18/13 at					
	8:52 A.M., the						
		Maplewood unit					
		igerator did not have					
	-	gs which indicated the					
	•	ad not been monitored 13 through July 17,					
	2013.	13 tillough July 17,					
	2010.						
	3.1-25(m)						
	, ,						

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Event ID: 53YG11

Facility ID: 000468

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	COMPLETED				
		155378			07/18/2013		
			B. WING	ADDRESS CITY STATE ZID CODE			
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE			
				GRANT ST			
SIGNATU	IRE HEALTHCARE	ATPARKWOOD	LEBAN	ON, IN 46052			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
F000520	483.75(o)(1)						
SS=E	, ,, ,	E-MEMBERS/MEET					
	QUARTERLY/PL	ANS					
	A facility must ma	intain a quality					
	assessment and	assurance committee					
	consisting of the	director of nursing services;					
	a physician desig	nated by the facility; and at					
	least 3 other mem	nbers of the facility's staff.					
		sment and assurance					
		at least quarterly to					
	•	th respect to which quality					
		assurance activities are					
	necessary; and develops and implements appropriate plans of action to correct						
	identified quality of	deficiencies.					
	A State or the Se	porotory may not require					
		ecretary may not require records of such committee					
		such disclosure is related					
	•	of such committee with					
	the requirements						
	the requirements	or time decition.					
	Good faith attemn	ots by the committee to					
	·	ct quality deficiencies will					
		basis for sanctions.					
		rvation, interview, and	F000520	F520-Committee-Members/Members	eet 08/17/2013		
		the facility failed to		Quarterly/Plans: 1. Describe			
		-		what the facility did to correct t	he		
		op an appropriate plan		deficient practice for each clier			
		ified dietary issues		cited in the deficiency. Effective			
	related to cold	food and extensive		7/15/13, facility revised serving			
	wait times for n	neals to be served.		times and staff allocation to			
	This deficient practice had the			ensure 2 staff members are			
	potential to affe			available in the main dining roo			
	•	resided in the facility.		15 minutes prior to serving tim			
	residerits with t	esided in the lacility.		to pass all drinks and serve tra	ays		
				timely. 2. Describe how the			
	Findings includ	e:		facility reviewed all clients in th			
				facility that could be affected b	-		
				the same deficient practice, an	iu		

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Event ID: 53YG11

Facility ID: 000468

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A RUILDING 00			COMPLETED		
		155378	A. BUILDING B. WING 07/18/2013			2013	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
CICNIATI	JRE HEALTHCARE	AT DARKWOOD			GRANT ST		
SIGNAT	JRE HEALTHCARE	EAT FARRWOOD		LEDAIN	ON, IN 46052		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	On 7/9/2013 at	t 11:30 A.M., an			state, what actions the facility		
	observation of	a sign posted by the			took to correct the deficient	4.	
	Rosewood Cat	fe dining area was			practice for any client the facili identified as being affected.	ty	
	made. The sig	ın indicated, breakfast			Effective 7/15/13, facility revise	ed he	
	_	8:15 A.M., lunch was			serving times for all dining are		
		5 P.M., and dinner was			and staff allocation to ensure		
	served at 6:15				enough staff in each serving a	rea	
	301700 010.10	1 .101.			to provide food timely. 3.		
	Constant shap	rvations were made of			Describe the steps or systemic		
					changes the facility has made	or	
		Cafe dining room on			will make to ensure that the deficient practice does not rec	ur	
		nning at 12:24 P.M.			including any in-services, but t		
	_	1:25 P.M. The			also should include any syster		
	following obser	rvations were made:			changes you made. Facility		
					in-serviced nursing and dietary	/	
	12:24 P.M 16	residents seated in			staff on 7/12/13, to educate sta	aff	
	the dining room	n waiting to be served.			on new dining plan. Serving		
	No food being	_			times were revised for accurac	СУ	
	_	e staff offering only			and staff were re-assigned to		
		his time. She indicated			different areas to ensure enou	-	
					staff in each location to provide residents timely meal service.	E	
		ne back and provide the			Administrator and Director of		
		n she was done. Carts			Nursing in-serviced by regiona	ıl	
	_	h trays of food to be			Director of Operations on Qua		
		areas in the facility.			Assurance process and effecti	-	
	12:35 P.M las	st person in the room			process improvement. The	;	
	was offered a	cold drink.			Dietician or designee will		
	12:39 P.M res	sidents who wanted hot			complete an audit of the meal		
	drinks were se	rved hot drinks.			service 3x daily for first 2 weel 1x daily for next 2 weeks, then		
	12:50 P.M las	st resident who wanted			weekly for 30 days, then 1x	JX	
		s served his drink.			weekly for 30 days. This will		
		t tray delivered to a			include timeliness of meals be	ing	
		is time, two staff			served, food temps and intervi	•	
		•			of 3 residents each day		
	observed servi	0 ,			alternating the resident who ea		
		cond tray served to a			the dining room and the reside	ent	
	resident				who eat in their room (see	\ -	
	12:56 P.M Re	esident yelled out,			Attachment I included with 256	57	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING COMPLETED			COMPLETED	
I 155378		B. WING 07/18/2013				
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEI	₹			GRANT ST	
	JRE HEALTHCARE	E AT PARKWOOD		LEBAN	ON, IN 46052	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
		food." Staff responded,			front page fax). The reside council minutes will be reviewed.	
	_	e are running behind."			by the Administrator and Dietic	
		of [now] 20 residents			following the meeting to ensur	
	sitting in the di	ning room had not			timely follow up of dietary	
	been served lu	ınch.			concerns. 4. Describe how th	ie
	1:10 P.M 10	residents not served			corrective action(s) will be	
	lunch				monitored to ensure the deficie	
	1:16 P.M 5 re	esidents still not served			practice will not recur, i.e., who	
	lunch.				quality assurance program will put into place. Facility will incl	• • • • • • • • • • • • • • • • • • •
		sident A was served ice			meal timeliness monitoring in	
		emoved the lid when			monthly quality assurance revi	
		The ice cream was			for next 6 months to ensure	
	melted almost				deficient practice does not rec	
		sident A was asked if			Regional Director of Operation	
					will review all Quality Assurance	
		cream melted. He			minutes to ensure that identific concerns are appropriately	ea
		it it's that way by the			worked through the quality	
	time it gets her				assurance process for the nex	t 6
	1:20 P.M the	last resident in the			months to ensure the deficient	
	room was serv	red lunch			practice does not recur.	
	During observa	ations on 7/10/2013 at				
	12:42 P.M., sta	aff served Resident A				
	ice cream that	was near liquid				
		Resident A stated, "Yes,				
	it is liquid agai					
	1 11 11 11 11 11 11 11 11	 j -				
	Interviews with	residents and family:				
	,,_,					
		:50 A.M., Resident P				
	indicated, at tir	nes her food is cold.				
	Her toast was	usually burned and she				
	ate a lot of pea	anut butter and jelly				
		ecause the food was				
	not so good.					
	I		1			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
155378			B. WIN	IG		07/18/	2013
NAME OF P	ROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	KOVIDEK OK SOTTEIEF				GRANT ST		
SIGNATU	JRE HEALTHCARE	E AT PARKWOOD		LEBANG	ON, IN 46052		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	7/9/2013 at 12	:05 P.M., Resident N					
	indicated, her f	food was cold more					
	than it was not						
	7/9/2013 at 12	:15 P.M., Resident L					
	-	warm and hot is warm					
	_	y get it too you You					
		eam. It was that way					
	_	d it is a shake and go					
	on if you like w	arm ice cream Yes,					
	I have not eate	en because it was too					
	cold or too hot when it should have						
	been cold."						
	7/9/2013-12:30	P.MResident C					
	stated, "There	is usually only one or					
	two staff in her	e serving, cutting, and					
	setting up trays	s. They need					
	something. I s	wear We are					
	supposed to be	e served at 12:15. I					
	come down he	re at 12:00 ."					
	7/9/2013-1:22	P.M Resident B's					
	family member	stated, "He has been					
	here since 11:3	30 A.M., He didn't					
	get his food un	til after 1:00 today.					
	That is too long	g Sometimes he gets					
	•	e will wheel himself					
	•	m without eating. He					
		several times"					
	7/9/2013 at 1:2	28 P.M., Resident E					
		Is were served late and					
	•	of the time she didn't					
	get what she o						
	Ser Milar Sile O	racica.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED B. WING 07/18/2013			PLETED	
NAME OF P	PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZII N GRANT ST	P CODE	
SIGNATU	JRE HEALTHCARE	AT PARKWOOD		ANON, IN 46052		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	indicated, most was not appetiz	A.M., Resident F t of the time the food zing. It was continually y late because there h staff.				
	stated, "I eat in it is cold. No ce on how long it t how warm it is	28 A.M Resident D my room. Sometimes ertain meal. It depends takes to get here and when it leaves the ice cream is usually n I get it"				
	the food taste gappetizing Ressucks. The ice milkshake. It is displeased with itI have told eindicated the forproper tempera	4 A.M., When asked if good and looked ident G replied, "It cream is like a strinkable I am so the food, I don't eat every body." He further ood was not served at atures and his family m food from the				
	indicated once not enough sta happened agai 7/11/2013 at 9: if the food was temperature, R	1:21 A.M., Resident I and a while there was ff to serve trays and it n last night. 49 A.M., When asked served at the proper esident H responded, oldeveryday its cold."				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		155378	B. WIN	IG		07/18/	2013
NAME OF P	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
TWINE OF T	KO VIDEK OK SOI I EIEI			1001 N	GRANT ST		
SIGNATU	JRE HEALTHCARE	E AT PARKWOOD		LEBANG	ON, IN 46052		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	7/10/2013 at 10:05 A.M., Resident K indicated she ate in the dining room. Her eggs were sometimes cold. She						
		ong time to be served					
		She further indicated					
		sometimes due to staff					
		ir job seriously" and					
	"sometimes the	eir was just not enough					
	staff down ther	re."					
	7/10/2013 at 1	1:38 A.M., Resident O					
		nad to wait up to an					
		ved at times in the					
	dining room.						
	=/40/0040 . 4	55 D.M. D					
		:57 P.M., Resident M					
	· ·	ite in his room and					
	sometimes his	food was cold.					
	7/11/2013 at 1	:14 PM, Resident F					
		ood is awful. I spoke to					
	· ·	coldand no variety."					
		·					
		:41 A.M., Resident F					
		eating breakfast. At					
		ndicated, her food					
		ter today because her					
	eggs were cold	a again.					
	Interview with	facility staff:					
	7/9/2013 at 1:3	32 P.M., Licensed staff					
		happens frequently.					
	The start times	s are late. There isn't					

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(X5) COMPLETION DATE

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155378	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/18/2013			
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT PARKWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION			
	staff at times." The minutes for March 2013 indicated, Residents felt there needed to be more staff. The minutes for April 2013, indicated, Residents had complaints of "food not being warm enough" and "wait times for meals." The minutes for May 2013, indicated, Residents had complaints of the "food not always being hot enough", the "ice cream is melted at times", and "meals are late at times." During an interview on 7/16/2013 at 9:24 A.M., the Administrator indicated the facilities Quality Assessment Committee had identified concerns with cold food and residents having to wait long periods of time to be served meals through observations and the Resident Council Minutes. She indicated the Resident Council Minutes in March alluded to problems with cold food and wait times, however, audits had not been started until July 1, 2013, to address the concerns. This Federal tag relates to Complaint IN00131013. 3.1-52(b)(2)						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		IDENTIFICATION NUMBER: 155378	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPI 07/18	LETED
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT PARKWOOD			1001 N	NDDRESS, CITY, STATE, ZIP C GRANT ST ON, IN 46052	CODE	
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE

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